STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

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12 VAC 30-60-10. Institutional care.

Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX.

12 VAC 30-60-20. Utilization Control: General Acute Care Hospitals (enrolled providers).

A. Prior authorization required. The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) shall not reimburse for services which are not authorized as follows:

1. DMAS shall monitor, consistent with State law, the utilization of all inpatient hospital services. All planned inpatient hospital stays shall be preauthorized prior to admission.

2. If a Medicaid eligible individual is admitted to inpatient hospital care, on a Saturday, Sunday or holiday, or after normal working hours, it shall be the provider's responsibility to obtain the required authorization on the next work day following such admission.

3. If a provider has rendered inpatient services to an individual who later is determined to be Medicaid eligible, it shall be the provider's responsibility to obtain the required authorization prior to billing the DMAS for these services.

4. Regardless of preauthorization, DMAS shall review all inpatient hospital claims for individuals over the age of 21 which suspend for exceeding the 21 day limit per admission in a 60 day period for the same or similar diagnoses prior to reimbursement for the stay until such time as DMAS implements DRG payment methodology. At such time only psychiatric inpatient hospital claims will suspend for this review.

5. DMAS shall review all claims which suspend for sterilization, hysterectomy, or abortion procedures for the presence of the required federal and state forms prior to reimbursement. If the forms are not attached to the bill and not properly completed, reimbursement for the services rendered will be denied or reduced, according to DMAS policy.

B. To determine that the DMAS enrolled hospital providers are in compliance with the regulations governing hospital utilization control found in the *Code of Federal Regulations*, 42 CFR, Chapter IV, Subpart C, §§456.50-456.145, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an

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appropriate place for the auditors to conduct such review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR §§456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR §§456.105 through 456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and list of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR §§456.141 through 456.145.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital is in compliance with the 42 CFR §456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification and written plan of care for each selected stay to determine the hospital's compliance with the 42 CFR §§456.60 and 456.80. If any of the required documentation does not meet the requirements found in the 42 CFR §§456.60 and 456.80, reimbursement may be retracted.

7. The hospitals may appeal in accordance with the *Code of Virginia* §9-6.14:1 et seq. any adverse decision resulting from such audits which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

12 VAC 30-60-25. Freestanding psychiatric hospitals.

A. Psychiatric services in freestanding psychiatric hospitals shall only be covered for eligible persons younger than 21 years of age and older than 64 years of age.

B. Prior authorization required. DMAS shall monitor, consistent with state law, the utilization of all inpatient free-standing psychiatric hospital services. All inpatient

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hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

C. If a Medicaid eligible individual is admitted in an emergency to a free-standing psychiatric hospital on a Saturday, Sunday, holiday, or after normal working hours, it shall be the provider's responsibility to obtain the required authorization on the next work day following such an admission.

D. In each case for which payment for free-standing psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric hospital consistent with §456.160.

2. The physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify, at least every 60 days, that the individual continues to require inpatient services in a psychiatric hospital.

3. Before admission to a free-standing psychiatric hospital or before authorization for payment, the attending physician or staff physician must perform a medical evaluation of the individual; and appropriate professional personnel must make a psychiatric and social evaluation as cited in the 42 CFR §456.170.

4. Before admission to a free-standing psychiatric hospital or before authorization for payment the attending physician or staff physician must establish a written plan of care for each recipient patient as cited in the 42 CFR §§456.180 and 441.155.

E. If the eligible individual is 21 years of age or older, then, in order to qualify for Medicaid payment for this service, he must be at least 65 years of age.

F. If younger than 21 years of age, it shall be documented that the individual requiring admission to a free-standing psychiatric hospital is under 21 years of age, that treatment is medically necessary and that the necessity was identified as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening. Required patient documentation shall include, but not be limited to, the following:

1. An EPSDT physician's screening report showing the identification of the need

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for further psychiatric evaluation and possible treatment.

2. A diagnostic evaluation documenting a current (active) psychiatric disorder included in the DSM-III-R that supports the treatment recommended. The diagnostic evaluation must be completed prior to admission.

3. For admission to a free-standing psychiatric hospital and before authorization for psychiatric services resulting from an EPSDT screening, a certification of the need for services as defined at 42 CFR §441.152 by an interdisciplinary team meeting the requirements of 42 CFR §441.153 or §441.156 and the Psychiatric Inpatient Treatment of Minors Act (§16.1-335 et seq. *Code of Virginia*) shall be required.

4. The absence of any of the above required documentation shall result in DMAS's denial of the requested preauthorization and coverage of subsequent hospitalization.

G. To determine that the DMAS enrolled mental hospital providers are in compliance with the regulations governing mental hospital utilization control found in the 42 CFR §456.150, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an appropriate place for the auditors to conduct such review if done on-site. The audits shall consist of review of the following:

1. Copy of the mental hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR §§456.200 through 456.245.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR §§456.205 through 456.206.

3. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR §§456.241 through 456.245.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital

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is in compliance with 42 CFR §456.245.

6. From a list of randomly selected paid claims, the free-standing psychiatric hospital must provide a copy of the certification for services, a copy of the physician admission certification, a copy of the required medical, psychiatric, and social evaluations, and the written plan of care for each selected stay to determine the hospital's compliance with the *Code of Virginia* §§16.1-335 through 16.1-348 and 42 CFR §§441.152, 456.160, 456.170, and §§456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

7. The hospitals may appeal in accordance with the *Code of Virginia* §9-6.14:1 et seq. any adverse decision resulting from such audits which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

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f. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

g. When the resident no longer meets long stay hospital criteria or requires services that the facility is unable to provide, the resident must be discharged.

C. Utilization control: Nursing facilities.

A. Long-term care of residents in nursing facilities will be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements. All nursing facility services, including specialized care, shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

B. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

C. The DMAS shall periodically conduct a validation survey of the assessments and medical records completed by nursing facilities to determine whether services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records. If provision of, or need for, services or the appropriate level of care are not demonstrated in the medical record, the DMAS shall deny reimbursement, retract reimbursement, or adjust case-mix calculations to accurately reflect the services and level of care provided or that should appropriately have been provided to any Medicaid recipient.

D. Nursing facilities must submit to the DMAS resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

E. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in Supplement 1 to Attachment 3.1C (12VAC30-60-300) (Nursing Facility Criteria).

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In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in Supplement 1 to Attachment 3.1C (12VAC30-60-320: Adult Specialized Care Criteria or 12VAC30-60-340: Pediatric/Adolescent Specialized Care Criteria). In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care services requirements are set forth below.

In each case for which payment for nursing facility or specialized care services is made under the State Plan, a physician must recommend at the time of admission or, if later, the time at which the individual applies for medical assistance under the State Plan, that the individual requires nursing facility care.

F. Reimbursement for specialized care must be preauthorized by the DMAS according to established guidelines for preauthorization recorded in the *Virginia Medicaid Nursing Home Manual*. If it is not demonstrated in the preauthorization process that a recipient meets the established nursing facility and specialized care criteria set forth in Supplement 1 to Attachment 3.1C (12VAC30-60-320 or 12VAC 30-60-340), the DMAS shall deny reimbursement.

G. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

H. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged. At the time that the resident no longer meets the specialized care criteria set forth in Supplement 1 to Attachment 3.1C (12VAC30-60-320 or 12VAC30-60-340), the resident must be discharged to the nursing facility level of care or other appropriate lower level of care.

I. Specialized care services: contract and scope of services requirements.

1. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with the DMAS to provide nursing facility care. In addition, providers must be certified to provide skilled nursing services by the Medicare program as it applies to Part A skilled (SNF) services.

2. Providers must contract to provide care to at least four residents who meet the specialized care criteria for children/adolescents or adults.

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3. Providers must assist Medicaid recipients in applying for third party benefits for which recipients may be eligible (including, but not limited to, assisting with the application for Medicare coverage, including assistance with the appropriate disability determination process to secure skilled (SNF) coverage and other applicable Medicare benefits or other third party coverage).

4. Providers must meet the contract approval standards that are set forth in Subsection J. to receive a new contract for specialized care services. As part of the review process for providers seeking a contract to provide specialized care services, DMAS shall complete a comprehensive two year history review of the facility which will include an examination of the licensure and certification survey reports from the Virginia Department of Health, reviews conducted by DMAS, and complaints received by the Department of Health, DMAS, and the Department for the Aging (State Long-Term Care Ombudsman Program). If the provider is a new nursing facility provider and does not have a two year history of providing nursing facility level of care, DMAS shall conduct a comprehensive review of the provider's status as a health care provider and make determinations based on the quality standards that reflect the criteria in this section deemed appropriate for contracting nursing facilities. If the facility has not been providing health care for at least two years, it will not be eligible for a contract for specialized care services.

5. In addition to the above specified review, the provider must document the ability to provide the services in accordance with the program scope of service requirements.

   Each component of the review will be evaluated according to the provider's ability to successfully meet all component requirements. If a requester does not meet one or more of the requirements, the request for contract will be rejected. A provider will not be awarded a contract if it is demonstrated in the two year review history that the provider has not been able to provide an adequate quality of nursing facility care as demonstrated according to the requirements set forth in Subsection J., or if the provider is unable to document the ability to provide the scope of service requirements as described in Subsection K.

J. Contract Approval Standards: The provider standards that must be met for new specialized care contracts are set forth below.

1. During the most recent two years, the provider cannot have been found to have "substandard quality of care" (as defined in the Health Care Financing Administration's nursing facility sanctioning guidelines) during the survey process by the Department of Health. The provider will not be allowed to participate in the program until a two year history is demonstrated without any "substandard quality of care" deficiency ratings.

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2. During the most recent two years, the provider cannot have any more than 3 justified complaints in any of the following category areas confirmed by the Department of Health, DMAS, and/or the State Long-Term Care Ombudsman Program and can have no more than 8 total justified complaints confirmed among the following categories: Residents Rights; Admission, Transfer, and Discharge Rights; Resident Behavior and Facility Practices; Quality of Life; Resident Assessment; Quality of Care; Nursing Services; Dietary Services; Physician Services; Specialized Rehabilitative Services; Dental Services; Pharmacy Services; Infection Control; Physical Environment; Administration.

3. During the most recent two years, the provider cannot have demonstrated a significant lack of compliance as identified in DMAS utilization review findings.

4. The provider must be able to document within the written contract application request the ability to provide all required services as specified in the contractual guidelines as defined in the scope of required services for specialized care in Subsection K.

5. If any of the above specified contract approval standards are not met by the requesting provider, the provider will not meet all components of the contract approval process and will not be granted specialized care reimbursement. A provider may reapply for a contract after the deficient area(s) is corrected in accordance with the above specified guidelines.

K. Scope of Required Services: Providers must provide the following specialized services to Medicaid specialized care recipients.

1. Physician visits by the attending physician at least once every 30 days. The attending physician must make the required 30 day visit. If a resident must be seen more frequently than every once 30 days, at the attending physician's discretion visits occurring in between the required 30 day visits may be conducted by a qualified physician's assistant or certified nurse practitioner.

2. Skilled nursing services by a registered nurse available 24 hours a day. A registered nurse must function in a "charge nurse" capacity whose sole responsibility is the designated nursing unit on which the specialized care residents reside. If specialized care residents are residing on more than one designated nursing unit within the facility, a registered nurse must fulfill the above specified requirement for each separate nursing unit housing specialized care residents.

   For Comprehensive Rehabilitation residents, nursing staff are responsible for rehabilitative nursing and supporting documentation. Rehabilitative nursing shall include the practice of skills learned or acquired during therapy sessions and the on-going clinical assessment and documentation of rehabilitative progress as a component of the required nursing documentation. The documentation must incorporate nursing-related impressions of the outcomes of the overall therapeutic regime, including progress as assessed on the unit. A registered nurse is responsible for the oversight of rehabilitative nursing practice, clinical assessment, and documentation required to meet the rehabilitative nursing requirement.

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3. Coordinated multidisciplinary team approach to meet the needs of the resident.

4. Infection control.

5. For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 450 therapy minutes per week (every 7 days).

6. For residents over age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 600 therapy minutes per week (every 7 days).

7. Ancillary services related to a plan of care.

8. Respiratory therapy services by a board-certified therapist (for ventilator patients, these services must be available 24 hours per day) related to the plan of care. Providers must assure that all residents who are ventilator dependent or who are receiving respiratory therapy in the complex health care category as defined in Supplement 1 to Attachment 3.1C (12VAC30-60-320 or 12VAC30-60-340) are seen by a respiratory therapist at least once every 14 days.

9. Psychology services by a licensed clinical psychologist, a licensed clinical social worker, or a licensed professional counselor related to a plan of care.

10. Necessary durable medical equipment and supplies as required by the plan of care.

11. Nutritional elements as required by the plan of care.

12. The same opportunity for specialized care residents to participate in integrated nursing facility activities as other residents.

13. Nonemergency transportation afforded in a manner consistent with transportation to community activities and events that is provided to all other nursing facility residents;

14. Discharge planning and ongoing utilization review. Discharge planning shall begin at admission and be an ongoing process for all residents during a specialized care stay. Utilization review shall be conducted and documented in the medical record by the interdisciplinary care plan team at least every 30 days to support that the resident continues to meet the specified criteria requirements for specialized care reimbursement. This review shall also be substantiated by the physician's documentation of utilization review of the necessary criteria and written support in the medical record of the resident's continued need for specialized care stay at least every 30 days; and